ADAP Advisory Committee Meeting
June 28, 2006
Virginia Department of Health
James Madison Building

Members present: Grayson Miller, MD, Craig Parrish, RPh, Donald Walker, Daniel Nixon, DO, Bob Higginson, PA, Linda Eastham, RN FNP, George Kelly, Robert Brennan, MD.

Department of Health staff present: Kathryn Hafford, RN MS, Diana Jordan, RN MS, Faye Bates RN, Steve Bailey, LCSW, Casey Riley, Celestine Buyu, and Carrie Dolan

Others present: Anne Rhodes and Miranda Smith

The meeting was called to order by Grayson Miller, MD at 10:00 a.m. with welcome, introductions, and approval of minutes. There were no amendments to the minutes.

Diana Jordan, Director of Health Care Services, provided an update on the Ryan White Title II grant award and ADAP funding. There was a reduction of funding by $850,000, which resulted in a $350,000 decrease in funding to the consortium and a net decrease of $500,000 for ADAP. The state still provides $2.6 million in funding. For 2006 total funding is $18.9 million. ADAP receives additional income from Medicaid back-billing, special pharmaceutical company rebates, and savings from Medicare Part D enrollment. This additional income for ADAP lessens the impact of the award reduction from the Health Resources and Services Administration (HRSA).

Medicare Part D and ADAP- HRSA initially mandated that Medicare eligible ADAP clients enroll in a Medicare Part D Prescription Plan (PDP). The directive was that ADAP may assist clients with cost sharing if this would be cost neutral, but this assistance would not count towards the true out of pocket (TrOOP) costs required to reach the catastrophic coverage level of the Part D benefit. A cost benefit analysis was conducted to determine cost effectiveness of providing this assistance. The cost benefit analysis showed that it was more cost effective to maintain clients on ADAP who were over 150% of the Federal Poverty Level (FPL). Policy was established that Medicare eligible ADAP clients with incomes 150% of FPL and above may remain on ADAP. Clients with incomes below 150% of the FPL are required to apply for the low income subsidy (LIS). Clients who qualify for LIS would have their premiums subsidized and have very low co-pays. Therefore, they would no longer be eligible for ADAP. Clients who did not qualify for LIS would be allowed to remain on ADAP. Eligibility exception criteria were established for clients receiving a partial subsidy and unable to meet cost sharing expenses. Exceptions requests are reviewed on a case by case basis.

Just prior to the Medicare Part D enrollment deadline, HRSA instructed states to allow continued ADAP access for clients who fail to enroll in a PDP who do not have another viable option to obtain medication. A memorandum was sent to the local health

departments instructing not to withhold medications if clients have not enrolled, or refused to enroll, in a PDP. It was requested to document the refusal and forward to the VDH ADAP Coordinator. There has been one documented refusal received.

The proposed state budget has funding in the amount of $300,000 for establishing a State Pharmaceutical Assistance Program (SPAP). SPAP assistance with Part D cost sharing does count toward the TrOOP cost requirement which allows beneficiaries to reach the catastrophic coverage level of the benefit. The SPAP would be utilized to assist ADAP clients with Medicare Part D cost sharing including premium payments, co-pays and deductibles. There is a certification process through the Centers for Medicaid and Medicare Services before the program is initiated.

Celestine Buyu, Coordinator of the Medical Monitoring Project (MMP), gave a presentation of the project. MMP is a new surveillance project to produce nationally representative data on people living with HIV/AIDS receiving care in the United States. Goals include identifying risk behavior for HIV infection, care and treatment issues and to identify barriers to services.

Anne Rhodes, Community Health Research Initiative (CHRI), presented the ADAP Data report. For Ryan White Title II Fiscal Year 2005, the total cost of filled prescriptions totaled $23,818,875. However, there were other factors offsetting these costs, such as Medicaid back-billing, year end general state funds, pharmaceutical company special rebates, and free goods. Another factor is the redispensing of medication returns. The estimated savings generated by these sources are $3.5 million. With this adjustment, it is estimated that just over $20,000,000 was spent on medications.

There were several data requests made by the committee. One request was to include the number of clients who are on boosted protease inhibitor regimens broken down by region. Another request was for data concerning viral load and CD4 counts by region.

Dr. Dan Nixon gave a presentation on the recently approved protease inhibitor, Prezista (darunavir). This medication is approved for salvage therapy for the treatment experienced client. After the presentation, discussion took place regarding adding the medication to the formulary, and medical criteria for exception. Criteria were reviewed also for Fuzeon and tipranavir. The decision was made to add darunavir to the formulary by exception, and the medical exception criteria will be the same for Fuzeon, tipranavir, and darunavir. The medical criteria will consist of a CD4 count less than 300 or 20%, with a viral load greater than 400 copies. In addition client must be PI, NNRTI, and NRTI experienced or intolerant, and have 2 or more PI primary mutations. Laboratory testing of CD4 and viral load are to be done at least every 3 months.

Faye Bates gave a brief overview of Medicaid back-billing report. The most recent report showed a total of $1,308,675.00 recouped since the program began. The Seamless Transition report statistics were reviewed. There have been 537 referrals since September 2000, and 56% kept their initial ADAP appointment. The numbers for 2006 reflected 57% of inmates who did not keep appointments. The ADAP Coordinator is presently

working with the Department of Corrections Chief Nurse for Community Corrections in following up of inmates that did not keep appointments. The DOC nurse will check to see if inmates have returned to the corrections system, and also contact the parole officers for those that were under parole supervision. VDH will perform a data run of the inmates to determine if they entered ADAP at a later date, or through another locality.

Linda Eastham brought up the topic of adherence initiatives. The ADAP Coordinator will share with the committee at the next meeting adherence initiatives being done at the local health departments.

The next ADAP Advisory Committee meeting is scheduled for October 11, 2006. Place and time will be announced in a future communication.

Meeting was adjourned at 2:00 p.m.